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MOTIVATION AND SUCCESSFUL PHYSIOTHERAPY[1]

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You may wonder why a psychiatrist should talk to you about the unrelated subject of physiotherapy. As you know psychiatrists' thoughts and theories are at times unrealistic, their predictions less accurate than those of a mediocre astrologer, and their treatments less effective than those of a Chinese herbalist. However, I think that there is at least one extenuating circumstance for my presence here and that is that periodically treatment by osteopaths and homœopaths is more effective than treatment by physiotherapists. I hope to be able to make some comments on the reason for this most unhappy state of affairs, and more generally on why one person with a particular disability recovers in a certain time, whereas another with an apparently identical disability takes a considerably longer time, or does not recover at all.

Motivation as applied to human behaviour may be considered simply as the drive or urge which causes us to do things. The drives to obtain food when we are hungry, drink when we are thirsty and sleep during boring lectures are primitive animal drives familiar to all of us and easy to understand, although each one involves complex physiological changes in the body. The urge to look at a pretty woman, although one may have a very charming and amiable wife already, the urge to buy an extra frock or handbag, although one may already have an ample supply, are somewhat more complex, and no doubt can be explained much more satisfactorily by you than by me. Both of these urges however, imply a degree of unconscious motivation which is not explicable directly in ordinary terms of animal instinct. Some of us are continuously against the Government or revolting against all constituted authority, while others seem to have a continuous need to be sick. These latter people are commonly called neurotic and the motivation behind their behaviour in this respect is commonly unconscious. Such people have unconscious emotional problems which cause them to need to be continuously dependent on those around them. I hope to illustrate how motivation ranging from entirely conscious to entirely unconscious—that is, how much, consciously and unconsciously, the patient wants to get well—plays quite a considerable part in the success of any treatment, and today particularly in your treatment.

A further factor which must be considered is the influence of the type of society in which we are living. I suppose all of us reflect at times as to why we do things, and at this particular time of the year I reflect particularly on just why I am working to pay so much to the Deputy Commissioner of Taxation. It makes me wonder about a particular tribe of natives in New Guinea whose social customs dictate that it is an offence to have more goods of any type than one immediately needs, that is, to accumulate goods or wealth is a social offence. This is of course very different from the situation which exists in Western civilization where the accumulation of money assumes such importance.

If we examine some facets of various social systems we find that in Communism

[1] Read at the Eighth Biennial Congress of the Australian Physiotherapy Association, May, 1960.

there is a considerable degree of obligation on the part of the State to care for the wants of the individual, at least for those who are for the regime; while at the same time there is an equally great, or perhaps greater, obligation on the part of the individual to do his utmost to produce for the State. In American Capitalism the accent is on competitiveness with the individual doing the best for himself and secondarily for the State, while the State has a much smaller obligation to the individual. If the individual has money or can obtain money he can be educated; if he can work sufficiently hard to beat competitors he can be employed, but the State bothers much less about him if he does not meet these qualifications than appears to be the situation under Communism. To an extent in Australia we have the worst of both systems in that many individuals feel very strongly and acutely the obligation of the State to care for them particularly in times of illness, whereas they in return do not feel any strong obligation to the State to produce to their utmost for it. This results in very varying motivations to recovery from illness to a stage of employability when one considers that the benefits or pensions available to the sick range from a few shillings per week to an amount which may be greater than the individual would be earning if he were actually employed.

Now let us consider some of the varying aspects of motivation under different headings.

ANXIETY

Anxiety is essentially the same emotion as fear but, as a generalization, it is disproportionate to the threatening situation. All of us experience varying degrees of anxiety from time to time, but in general the sick person experiences more anxiety than the healthy person. An anxious person who has a painful part, either from an injury or infection, is more anxious or afraid about using it than is a non-anxious person. This may be apparent quite early in the treatment, particularly during physiotherapy, when the patient appears not prepared to put as much effort into exercising his part as might be expected considering the degree or nature of his disability. With passive movements when he is distracted, a range of movements is obtained which is considerably greater than that during active movement when he is watching closely. Alternatively, the part will be moved through a greater range of movement during some manœuvre when his attention is distracted, as, for instance, when he is playing a game and his attention is devoted mostly to winning. This anxiety may and frequently does persist when the patient has returned to work, and it often tends to be most pronounced in those patients who suffer from painful backs. There is often a background fear that stooping, bending or lifting may cause a recurrence of the previous injury, although in fact the back is sufficiently stable for this not to occur. The individual then protects his back. He may have in addition secondary fears about losing his job; that is, he knows that his job is somewhat precariously held, either because he is not a particularly efficient worker or because there is a degree of unemployment in his particular trade and he fears that any further time off will cause him to be out of work. In these circumstances it is fairly easy to see that this patient will want to make quite sure that his back is stable before he returns to work; that is, he may want a period of a month or so extra before he feels sufficiently safe about his back to return to his previous occupation. Other anxieties as, for instance, about wife and family, may further aggravate his condition in the same way.

Anxiety commonly results in an increase in tone of the body muscles generally and more frequently those about the protected part, so that in fact there is added spasm, and as a result of this spasm, added pain.

The medical assessment of how much of this pain is due to the original organic lesion, how much to spasm of muscle due to anxiety, and how much simply to a fear that the part may be injured, is an extremely difficult one, and for the most part cannot be resolved into accurate figures or percentages. At best, one can say that anxiety is playing no part, that

it is playing a small part, that is is playing a major part or that it seems to be the entire cause.

By no means unrelated is anxiety on the part of the doctor regarding the degree of risk that he should request an injured patient to take in returning to his work. There are some cautious or kindly doctors who wish to be quite sure that the injured part is completely stable before work is attempted, while there are harder or more realistic doctors who push their patients back to work sooner. The former type of doctor will, of course, have fewer relapses of the injury or disability than the latter, but at the same time he will potentiate and prolong the hysterical or anxious part of the illness in many others where this is an important factor, and he, in fact, will make more permanent neurotic invalids than will the latter type of doctor.

It is quite amusing to see at times what doctors who have painful or unstable backs themselves will do in their own personal lives, and the abuses to which they will subject their backs, when they would never consider making a patient take the same risk. On the whole, it is to their credit that they have such concern over their patient's welfare. But surely, if taking such a risk with their own backs seems to them reasonable, it should equally be reasonable for their patients.

HYSTERIA

In hysteria there are deep emotional conflicts which for the most part develop during the very early years of a child's life and which result in a tendency to illness and retreat from difficult situations. They frequently show themselves as physical symptoms or as exaggerations of, or overlays to, physical symptoms due to organic illness. Marked hysteria is not uncommon in the community and mild degrees of hysteria are common. Such people get appendicitis or injuries just as frequently as any one else and it follows automatically that a considerable number of those who come under the care of physiotherapists are suffering from some degree of hysterical manifestation. Life for the hysteric is difficult because his whole relationship with people and with life generally is disturbed; hysterical symptoms provide for him a retreat from the difficulties to which everyone at times is subjected, or even from the difficulties of everyday living. The superficial recognition of hysteria is not as easy as that of anxiety because patients are frequently not obviously fearful or tense, but, on the other hand, there is a tendency to exaggeration or histrionics about their complaints, and as usual there is the failure to improve in what would be regarded as the usual period and an exaggerated incapacity in terms of the apparent severity of the physical injury. Again the hysterical element in an incapacity may range from zero to 100%. When of minor degree, the hysterical manifestation may be merely an elaboration of symptoms because at the time life seems just too much for the individual to cope with, and a further period of doing nothing would be nice for him. In a period of weeks he may again feel strong enough to face life and may not provide a problem.

More severe incapacity may be illustrated by a middle-aged woman who presented with two years' history of a painful back, with no radiation of pain to the legs. The history revealed that she had had a most unfortunate life, that she had had difficulties with her parents, that she had been raped on three separate occasions, had had to marry two of the men, bearing their children, that the marriages had failed, and that finally she had embarked on a third marriage with a man who turned out to be not what she expected. She had had to work most of her life as her two previous marriages had terminated immediately after the children were born, and she had had the responsibility of rearing the children.

These aspects of her life appeared to have no immediate bearing on her back, but the orthopædist treating her thought it desirable to have further psychiatric assessment. This revealed that she had a grossly hysterical personality which had not previously manifested itself to any great extent in physical symptoms, but which had influenced markedly her emotional behaviour through life. In general it is true to say that unless it be in war or other similar circumstances no woman is unlucky enough to be raped on three occasions unless in some way the situations arise in part through her own making. She had in fact had a very disturbed relationship with her father, whom she both loved and hated but who was the most important man in her life. She had a fixation on him. The

result of this was that her feelings of love towards men in general were disordered to the extent that when she loved a man she identified him with her father, and of course since intercourse with one's father is taboo, she was frigid with all men whom she could love. When the culmination of love was approaching she would immediately object and reject, so that in one sense she had been raped although she had always been a soliciting party. Following her early unfortunate experiences, for a long period through young adult life and middle age she conducted a number of abnormal relationships with men in which they persisted in love with her but she would allow no physical advances of any sort. She was provocative, yet cold; she hated men for what they had done to her, but still wanted to be loved by them.

Then eventually, a few years ago, she married an elderly man whom she thought would be kind and considerate, and give her the full satisfaction of her love. Soon after marriage she found that she was still frigid, and later found that her husband had a tendency to flirt. This resulted in many bitter arguments and recriminations. Eventually in one of them he pushed her and she injured her back. Immediately afterwards he was extremely sorry and guilty over what he had done to her and so he had nursed her carefully and gently and considerately ever since. Because of her painful back, he had not wished to make any physical advances to her so aggravating her pain. In fact, she had him in a vice-like grip from which he will never escape unless he deserts her. She has his constant devotion, attention and, most important, self-effacement before her for what he has done, but she does not have to suffer his physical advances. She is punishing him continuously for what he is—a man. The injury to her back was a minor one not causing significant symptoms for a period of a month or more after the injury. This back will never get better because it provides a situation which satisfies her almost completely emotionally, and consequently little help can be expected from orthopædic, or physiotherapeutic procedures, or for that matter from psychiatry, because the emotional conflicts are so long standing and so fixed. This is an example of unconscious motivation preventing recovery.

OBSESSIONAL NEUROSIS

Obsessional neurosis is a condition in which there are recurring thoughts, emotions or actions which are resisted by the individual as being foreign to him, but when resisted cause a degree of anxiety which usually leads to the repetition of the thought or act. In mild degrees, the person has a make-up which is perfectionist, meticulous, rigid, with a need to run to a system. These then provide a motivation which is positive towards recovery from illness. If such people are set a task of exercises they can be relied upon to stick to them meticulously and to carry them out without observation. When their obsessional condition is mild, they will put everything they have into recovering from physical illness or disability, and they should be a delight to most physicians and physiotherapists. However, if the obsessional condition is marked, there is a degree of disorganization of behaviour which will not allow of flexibility and persistence of effort and the patient may be completely incapacitated by his condition.

OTHER PSYCHIATRIC CONDITIONS

In other psychiatric conditions there is a generalized diminution in motivation or effort. The depressed patient does not care whether he gets better from his illness or not, and so will not apply himself to recovery. The schizophrenic patient in general is wanting to withdraw from life owing primarily to unconscious or genetically determined factors. Hence efforts to bring him back to social effectiveness in the community need to be at a greater level than for the healthy individual. The patient suffering from organic brain damage, whether from dementia, cerebral tumour or a "stroke", and the mentally defective are unable to cooperate intelligently and consistently with treatment, and so require a degree of added encouragement and attention. Depending on how severe their condition is, physiotherapy may have to be limited to procedures which do not require the active cooperation of the patient at all.

MONEY

In our civilization success and the acquisition of money, both frequently associated, are amongst the goals in life most emphasized from our early school days. Certainly there are sections of the community who are dedicated to the arts, sciences or other pursuits and who place their subject of interest first, with money a comparatively secondary objective. However, if one speaks to numbers of artists, one finds that they also are interested in

money, or rather their individual lack of it; they are frequently valuing their works and almost invariably thinking that they should be worth more. Professor Harry Messel, so noted for his great devotion to the interests of science generally and to the scientific education of students, still finds time to notice that his salary compares unfavourably with those of some doctors, and implies either that his should be greater, or that theirs should be less. Altogether in our society it is almost impossible to consider motivation to behaviour, and particularly to work apart from consideration of the incentive or motivation to acquire and possess money and wordly goods.

Consequently the monies payable as benefits, pensions and compensations to those suffering from sickness are of considerable importance in influencing the outcome of sickness. It is necessary to examine briefly some of these monies which are available.

Sickness benefit is paid to sick or injured employees during the period of their sickness. The rates[1] range from £1.15.0 per week for a sixteen-year-old single person to £6.12.6 for a married person with a child or children.

Invalid pensions are paid to those persons who are 85% permanently incapacitated for work, but the pension is subject to a means test. The rate is £4.15.0 per week for a single person, £6.10.0 per week for a married one plus 11/6 per week for the first child and 10/- for every subsequent child. It thus follows that the more children an individual on the invalid pension has, the greater is his income. I have frequently been impressed by the mounting pensions, and the mounting numbers of children of those who are 85% permanently incapacitated for work. It has been said that they have to spend their time doing something, but I do not know of any scientific investigation to support this contention.

In Queensland, workers' compensation is paid by the State Government Insurance Office to workers injured or sick due to their work or in the course of travelling to or from it. The rate is £11 0.0 per week plus £2.10.0 for wife plus 15/- for each child under the age of sixteen years. The maximum weekly amount, however, cannot be greater than 75% of the average income over the preceding year. This averaging provides some interesting situations in those who engage in seasonal work which may bring them in £40 to £60 per week during certain periods of the year, and who are unemployed or sick due to injury in other periods.

Repatriation pensions range from 11/- a week to the "totally and permanently incapacitated" rate. The latter, for a married man with two children, for example, is £14.13.0 per week plus various extras—free medical treatment, education allowances for children up to University standard, sales tax reductions as, for instance, on a motor car, free tram passes and railway concession fares. In all it can amount to an appreciable rate.

There are many insurance schemes available against sickness, perhaps the most important group being those run by various medical and hospitals funds and supported by the Commonwealth Government. The benefits from these can be considerable, and not infrequently the returns from the insurance are greater than moneys expended on hospital treatment. This, of course, applies particularly in a State which has a free hospital system. With these it is possible to make a profit out of illness and if the sick person is not losing wages, of course, the longer the sickness continues the greater is the overall financial advantage.

In a different category are the "lump sum" settlements paid for the loss of function of a particular part by insurance companies and the damages which may be awarded by a court. For example, the sum for loss of a thumb is £650, for loss of a leg £1,750. Damages awarded by a court may of course be up to and above £20,000, a sum of money in cash which a very small percentage of the community ever has in its possession at one time.

[1] Figures quoted are those operative as at April, 1960.

Whereas there are those in the community who will refuse, under any circumstances, to enter into litigation following injury, I think it is reasonable to say that the average individual once he is sueing is not going to underestimate the extent of his incapacity. He is not going to say in court "I have lost a hand, but I can do very well without it". He knows not very long after his accident that he is going to sue for damages and not very long after that he usually has some idea of the amount his solicitor has in mind. Considering the frailty of human nature, it would seem obvious that there are many, who, never having had in their lives more than £20 or £30 spare cash, and having the prospect of maybe five, ten or twenty thousand pounds in cash, will not subject themselves too much to the painful process of getting a joint moving, when they have very definitely the thought that the injury was not their fault anyhow, and it is up to someone to pay them for it. It is an interesting but sad comment that invariably the solicitor for the defence is well aware that the plaintiff may be influenced by such factors, but all too frequently the doctor who has been treating him in a preceding period is quite unaware that he even has a claim for damages, let alone has he any knowledge of the amount that is being claimed.

Hire purchase has a bearing on the motivation to get well, and very frequently puts a strong pressure on the individual to return to work as soon as possible to meet his hire purchase payments lest his refrigerator or washing machine be repossessed. However, even this positive motivation to return to work is being increasingly negated by extended insurance policies which will meet the repayments during a period of incapacity.

Considering these various moneys available it is immediately apparent that the majority of people will not be able to live comfortably or in their ordinary style on the sort of money which comes in from sickness benefits. These people in the majority of situations have a strong financial pressure to return to work. The pressure is somewhat less where invalid pensions are concerned, less again with workers' compensation and some medical benefits insurances, but in both of these there may be a negative motivation to return to work because there is financial gain. If the plaintiff in an action for damages can produce medical evidence that he is permanently unemployable he clearly can expect a greater sum than if he has returned to work or it is anticipated that he can do so. Such a claimant seeking a medical certificate is not going to understate his incapacity. However, the medical profession is not completely ingenuous and we do have a number of methods of assessing of these tendencies, although they must be regarded as far from accurate. Physiotherapists, of course, through longer observations of performance in settings more like ordinary conditions than a doctor's consulting room, can provide additional information which is of considerable value.

I would now like to describe one patient of the very great many there are whose illnesses are influenced by money. He is a male aged 25 years, who slipped while lifting a drum, made a grab to support himself, dropping the drum, and he strained his back. He did light work for two weeks but the back was still painful and he went off on compensation. He had persisting pain with some radiation down both legs, and he was given physiotherapy. He failed to make progress and after several months he was also developing terrific pain in his right arm with a feeling that it was half numb, and also headaches. These additional symptoms were clearly in no way related to the original injury and so he was referred for a further opinion. Physical examination had been quite normal except for a slight kyphoscoliosis.

His wife was 22. They had four children of an age range from 4 years to 2 months, the last three not having been intended. He was a bit worried about the physical side of marriage because his wife previously had seldom enjoyed it but since the last two children had been getting no satisfaction at all. His exercise tolerance was variable. He went swimming to help his back, but after each occasion it was very painful for three or four days. He had intercourse every second or third night, apparently without any trouble to his back. He was not sufficiently bright to see any apparent conflict in these two statements. He had no money worries, and owed only about £2, that being to a doctor. He was just keeping up with his hire purchase payments. He was getting £16.10.0 per week in Workers' Compen-

sation which was £1 more than his usual wage of £15.10.0. This was helping him considerably in meeting his hire purchase payments. This situation had arisen because of the seasonal nature of the industry in which he was employed. He had worked a considerable amount of overtime in the preceding months of the year, but the current time was a slack period and no overtime was available.

In summary he had a somewhat inadequate personality and he had had multiple jobs in the past. His intelligence was average to low average. His background worries were not great consisting mainly of rows over the children. There was a secondary concern that his back might be permanently incapacitated, but he did not worry much about this. His motivation to return to work was negative because it would mean financial loss. In other words, in such a situation for such a person, the obvious solution was to continue as he was. He was consciously motivated not to return to work. I referred him back to the referring orthopædic surgeon with this helpful information, and left it in his hands to get the person back to work. Somehow I keep forgetting to ask him how this patient has been progressing.[1]

There is one further aspect to the influence of money on illness which does not get any significant attention from Government, insurance organizations or benevolent funds, because they have no direct financial interest. It is the people who have money and can afford to be sick. The principles regarding motivation to work are no different from those in any other group. I suppose in general the medical profession and allied professions want to see these people back in gainful employment just as much as they wish any other group, but I have a sneaking feeling that the degree of pressure they apply may not be as great, the degree of tolerance of their complaints may be a little bit more, provided, of course, hospital medical and physiotherapy fees are being paid. There is no direct pressure from society to see that they recover from their illnesses at the moment, but no doubt the Communists would regard them as parasites on the community, and it is possible that they might do something about eliminating this social injustice.

THE PHYSIOTHERAPIST'S DILEMMA

I think that most people want to work most of the time and that they are happier working. Most, certainly, do not want to work as hard as they do, and they would like more money for less work than they do. Financial considerations apply in probably more than 50% of people who are sick regarding their motivation to return to work. Some are forced to return to work too soon, but in many there is not a sufficient pressure financially to cut short illness. The financial factor should be considered with every patient.

The incidence of psychiatric disorder in the community has never been accurately determined, but the usual sort of figure given by general practitioners is that between 25% and 40% of their patients either have primary psychological disorders or psychological overlays to physical disorders. It can be expected that the same percentage of psychological disorder will exist in the patients that you treat. Many of you through experience, others through training, already recognize these factors and modify your techniques accordingly. The recognition of some of these features, however, is really the province of a specialist and is the responsibility of the physician treating the patient.

Some of these aspects can be corrected by the physiotherapist, others only by a physician, others not at all. Assessment of the latter group is of very considerable importance as it modifies the aims, methods and limitations of treatment, including whether the outcome of surgery is likely to be successful or not, and so whether surgery should be undertaken.

Orthopædists generally are as ignorant of psychiatry as are psychiatrists of orthopædics. Thus it happens frequently that an overall assessment cannot be made by any one individual. However there are many reasons why dual or multiple assessments are not as good as a single over-all one.

Physiotherapy is one aspect of treatment of sick or injured people. Until the physician in charge of a patient can make an overall assessment, he cannot define for you the range or limitations of what is expected of you, that is, he cannot give you a general plan. The detailed technique, of course, must always be your

[1] He subsequently ceased to attend.

own province primarily. Considering for a moment those unqualified people who practise their art with a deal of mumbo-jumbo and self-assurance as do some herbalists, homœopaths and others, we find that by virtue of the strong suggestion which they exercise over neurotic individuals and the faith that the latter have in them, they effect not infrequently cures that recognized therapists do not. There is no doubt that we all at times use our aura of training, skill and authority to influence patients. The doctor's bedside manner, although the subject of many jokes, is an important aspect of the treatment of the patient as a patient, rather than as a case of such and such an illness. I think that if we can learn why the techniques of these untrained persons are successful at times, we can then incorporate the principles in our own treatments so improving them, but without the mumbo-jumbo of seances, clicking instruments for when the disc slips back, and impressive instruments with flashing lights. I must say, however, that when I think of that collection of complex apparatus that physiotherapists have, and then of my bare and unimpressive consulting room, you people are off to a very good start.

All too frequently the recognition of the existence of psychological factors, or of lack of motivation, occurs only when there has been a failure of improvement as anticipated, and this may not be for many months. When these factors are present, their early recognition is of considerable importance, not only because of time wasted in treatment, but because the disabilities tend to become fixed or chronic. Active treatment which may mean a programme of eight hours a day divided between physiotherapy, occupational therapy, and trade work is often essential if such patients are to recover at a maximum rate.

I think that physiotherapists, and especially experienced ones, quite often recognize this failure of improvement, or lack of motivation, earlier than does the physician in charge of the patient. I think this must be communicated to the physician, although just how this is done must depend on the particular situation in a particular institution, on the degree of liaison existing, and on the personalities involved. It may require considerable tact, as I am quite sure that most of us physicians do not like being instructed by ancillary workers as to how to treat our patients. But perhaps it is not an insurmountable problem, as most physicians are men, and most physiotherapists are women, and it has been an established fact from time immemorial that women have a way of getting around men.